PREMIUM CONVERSION WAIVER FORM

RECIND SECTION 125 FOR PREMIUM PAYMENT

EFFECTIVE DATE: _____

EMPLOYEE INFORMATION EMPLOYEE ID: _____

Name: _____ SSN: _____

Last First MI

Address: _____

By completing this form, your premium payments will be paid on a taxed basis year after year.
If you want your premiums to be paid on a pre-tax basis under Section 125, you should not complete this form.

Please check next to the coverage(s) you currently carry through the City of Salem.

Medical Plan _____

Dental Plan _____

- I understand that I cannot change or revoke this contribution election at any time during the Plan Year unless I have a qualifying status change that is consistent with my requested change.
- Prior to each Plan Year, I have the opportunity to rescind this election for the upcoming Plan Year. Failure to complete and return a new election form will be treated as having elected to continue the insurance coverage and payment method currently in place.
- The Plan Administrator may reduce, modify, or cancel this agreement in the event the Plan Administrator believes such action is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- I understand that this election governs the payment method for premiums offered under Section 125 which is implemented on behalf of all employees unless this negative election form is on file.

I have read and I understand the Premium Conversion Waiver Information as outlined.

_____ _____

Employee Signature Date